ARIZONA DEPARTMENT OF HEALTH SERVICES
High Risk Perinatal Program/Newborn Intensive Care Program
Request for Neonatal Transport

PLEASE PRINT

INFANT'S INFORMATION

1. Infant's Last Name	2. Suffix	3. First Name	4. MI	5. DOB

6. Alias: Last Name	7. Alias: First Name	8. Gender M F U	9. Place / Hospital of Birth

10. Street Address	11. City	12. State	13. Zip	14. County

15. Infant's Insurance Coverage Type ☐ 3rd Party Private ☐ AHCCCS ☐ KidsCare ☐ IHS non-AHCCCS ☐ None

FAMILY INFORMATION

16. Mother's Last Name	17. Mother's First Name	18. MI	19. DOB

20. Alias: Last Name / Maiden Name	21. Alias: First Name	22. Phone:

23. Father's Last Name	24. Suffix	25. Father's First Name	26. MI	27. DOB

TRANSPORT INFORMATION

28. Authorizing Physician: (Program Neonatologist)	29. Transport Date:

30. From Facility:	31. To Facility:	32. Transport Type: ☐ Enrollment ☐ Forward ☐ Back

33. Team ☐ Neonatal	34. Air - Fixed Wing ☐ Name of Air Transport Co	35. Air - Rotor ☐ Name of Air Transport Co	36. Ground Emergency ☐ **LEG 1** Name of Ground Co

37. Ground Emergency ☐ **LEG 2** Name of Ground Co	38. Ground Emergency ☐ **LEG 3** Name of Ground Co	39. Ground Back ☐ **LEG 1** Name of Ground Co	40. Ground Back ☐ **LEG 2** Name of Ground Co

41. Diagnosis/ Reason for Transport

The State of Arizona has established a High Risk Perinatal Program / Newborn Intensive Care Program (HRPP/NICP) to provide a system of Transportation, Hospital and Medical Services and Follow-up for critically ill newborns whose parents reside in Arizona.

If this is an <u>initial</u> transport, the family must complete the *HRPP/NICP Request for Participation* at the contracted receiving Hospital. The family must also complete the *HRPP/NICP Financial Worksheet* & the *HRPP/NICP Financial Questionnaire* at the enrolling Hospital if they are requesting financial assistance.

I authorize the transport of my child and the release of any necessary medical, social and financial information held by any institution or individual that provided newborn services to my child to the Arizona Department of Health Services and their contracted providers for provider quality management purposes. I understand that if this is an <u>initial</u> transport, my child will be enrolled in the Transport component of the HRPP/NICP only, and that I must choose to enroll or decline participation for Hospital and Follow-up components of the HRPP/NICP at the Enrolling Hospital.

Signature of Parent/Guardian/Responsible Party _____ Patient Relationship _____ Date _____

Signature of Transport Staff _____ Printed Name of Transport Staff _____ Date _____

Distribution by Transport: Original to ADHS Yellow to Transport Pink to Family
6-HRPP-011 HRPP/NICP NeoTransport 6//06